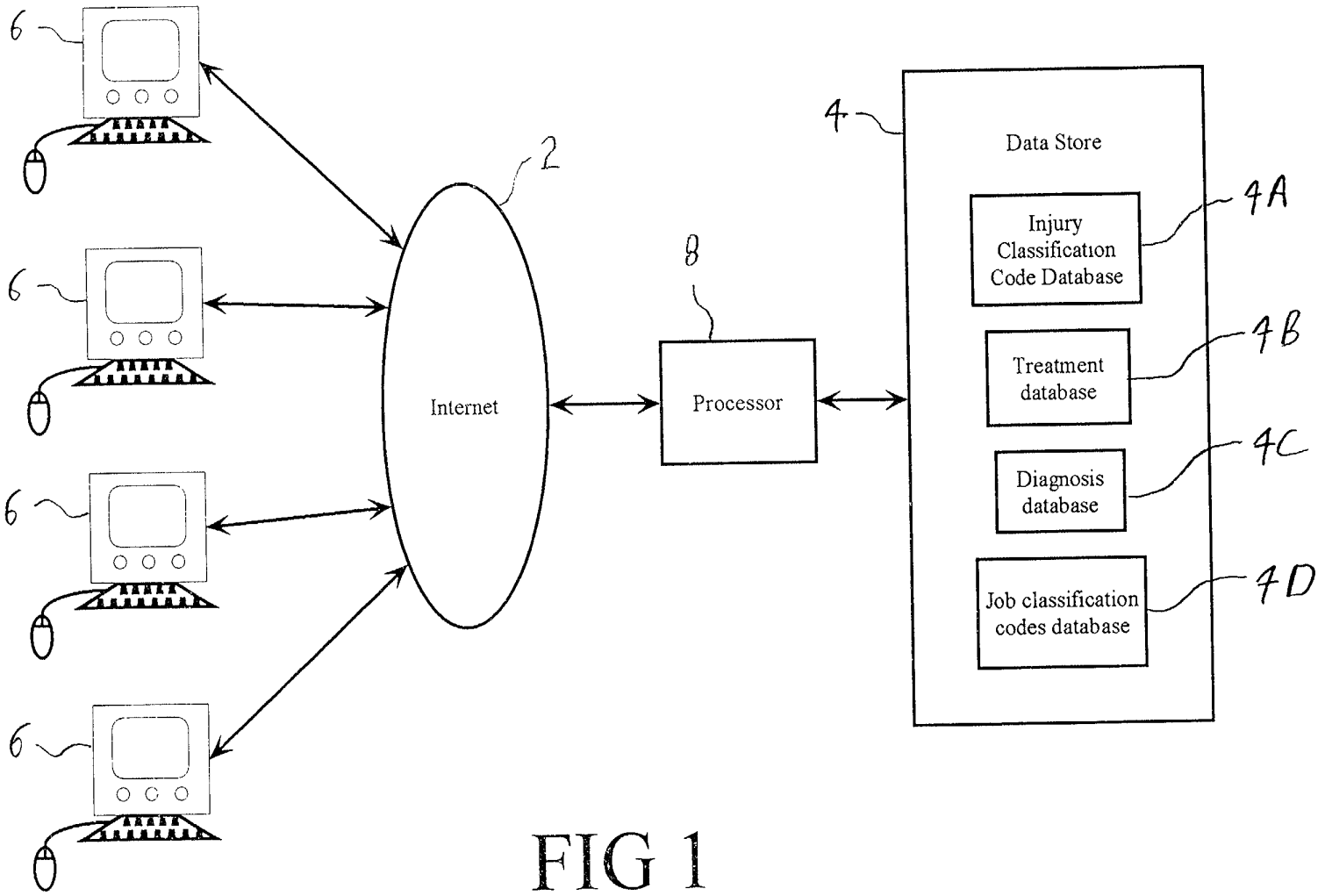


FIG 1

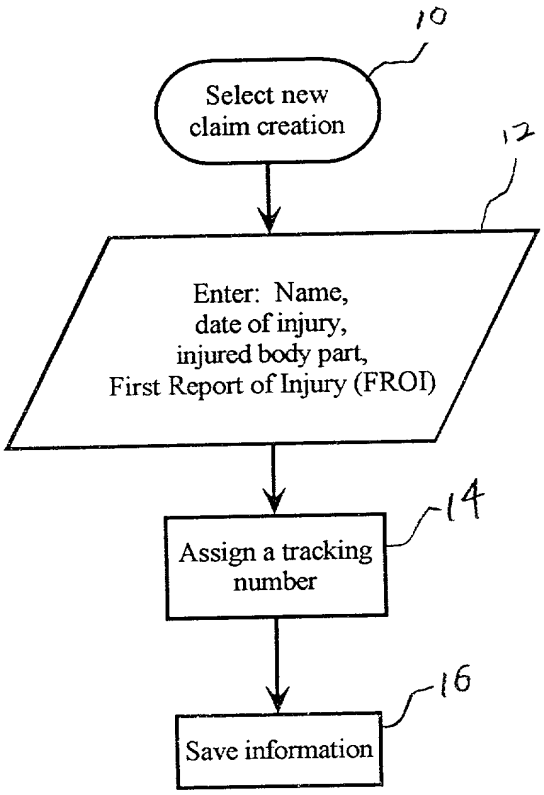

10
Select new claim creation
12
Enter: Name, date of injury, injured body part, First Report of Injury (FROI)
14
Assign a tracking number
16
Save information

FIG 2

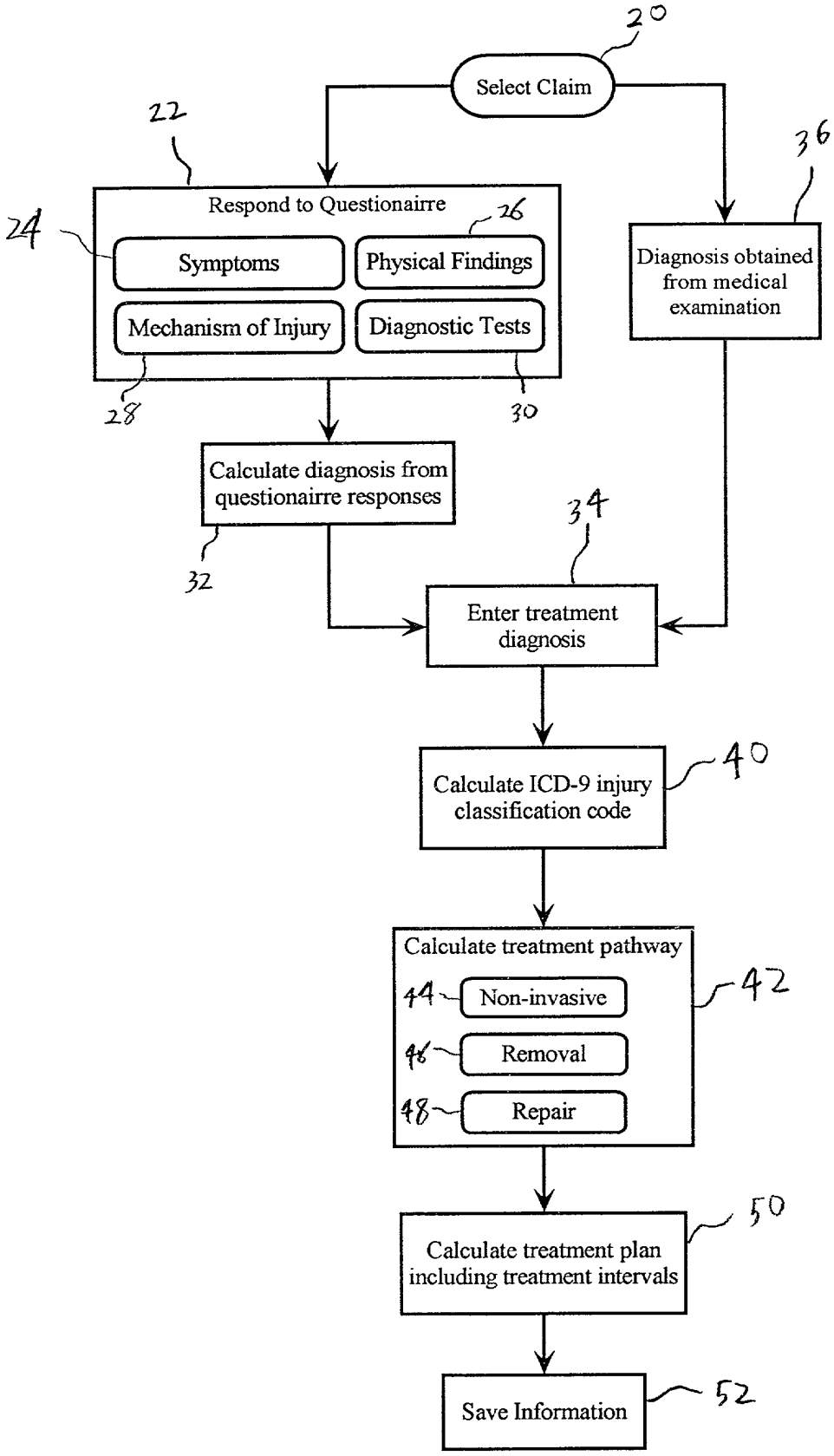

20
Select Claim
22
Respond to Questionairre
24
26
Symptoms
Physical Findings
Mechanism of Injury
Diagnostic Tests
28
30
36
Diagnosis obtained from medical examination
Calculate diagnosis from questionairre responses
32
34
Enter treatment diagnosis
Calculate ICD-9 injury classification code
40
Calculate treatment pathway
42
44
Non-invasive
46
Removal
48
Repair
Calculate treatment plan including treatment intervals
50
Save Information
52

FIG 3

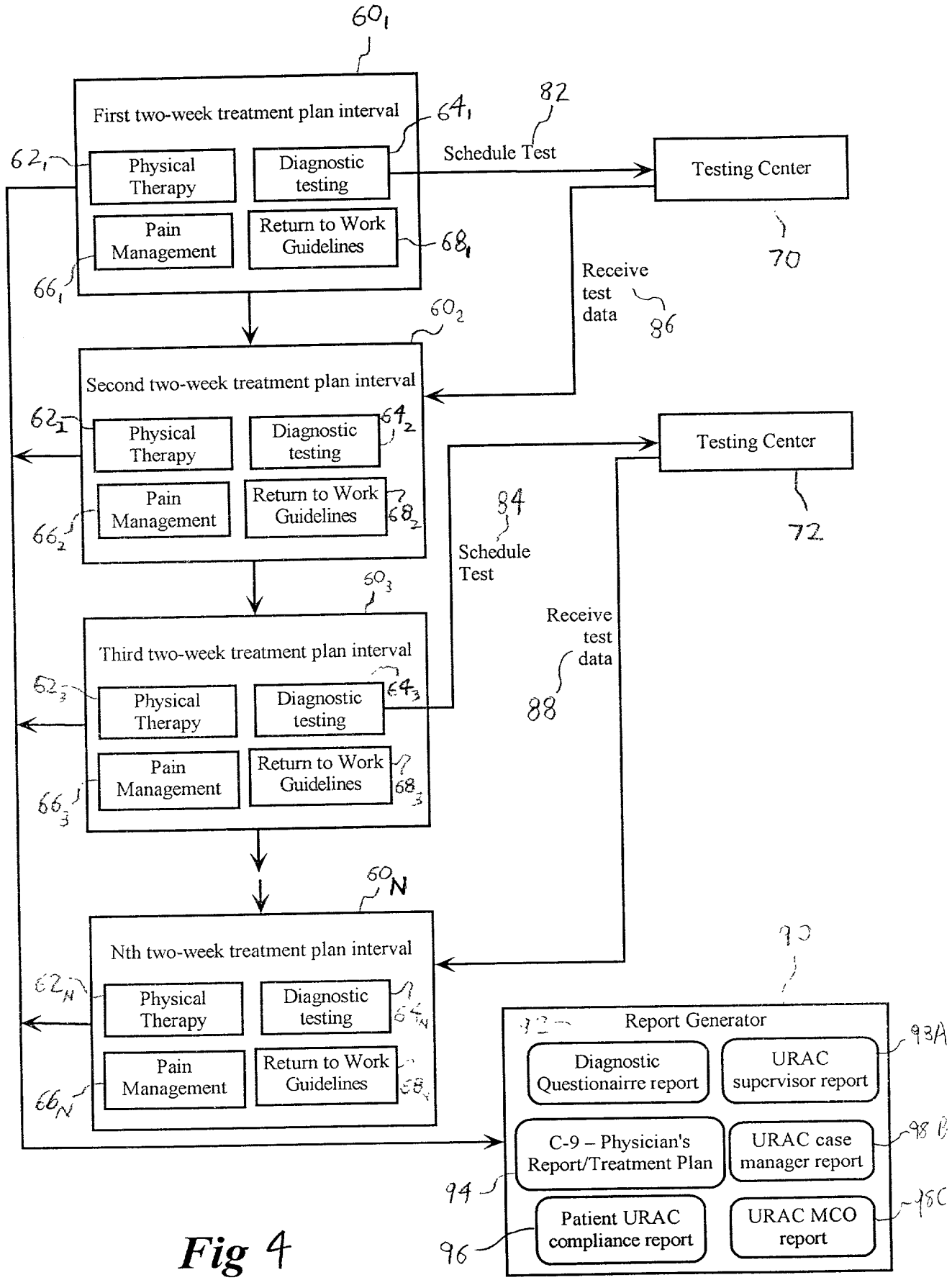

60 1
First two-week treatment plan interval
64 1
82
62 1
Physical Therapy
Diagnostic testing
Schedule Test
Testing Center
Pain Management
Return to Work Guidelines
68 1
66 1
70
Receive test data
86
60 2
Second two-week treatment plan interval
62 2
Physical Therapy
Diagnostic testing
64 2
Testing Center
Pain Management
Return to Work Guidelines
68 2
66 2
84
Schedule Test
72
60 3
Third two-week treatment plan interval
Receive test data
88
62 3
Physical Therapy
Diagnostic testing
64 3
Pain Management
Return to Work Guidelines
68 3
66 3
60 N
Nth two-week treatment plan interval
90
62 N
Physical Therapy
Diagnostic testing
64 N
Report Generator
92
Pain Management
Return to Work Guidelines
68 N
66 N
Diagnostic Questionairre report
URAC supervisor report
93A
C-9 – Physician's Report/Treatment Plan
URAC case manager report
98 B
94
Patient URAC compliance report
URAC MCO report
96
98C

Fig 4

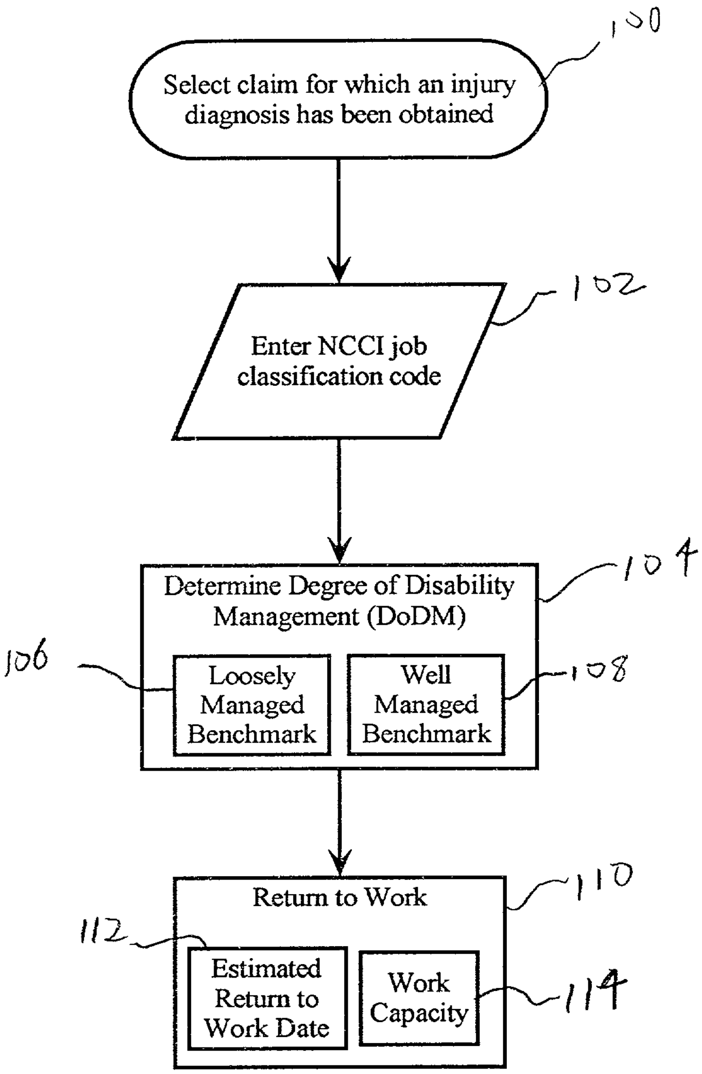


FIG 5

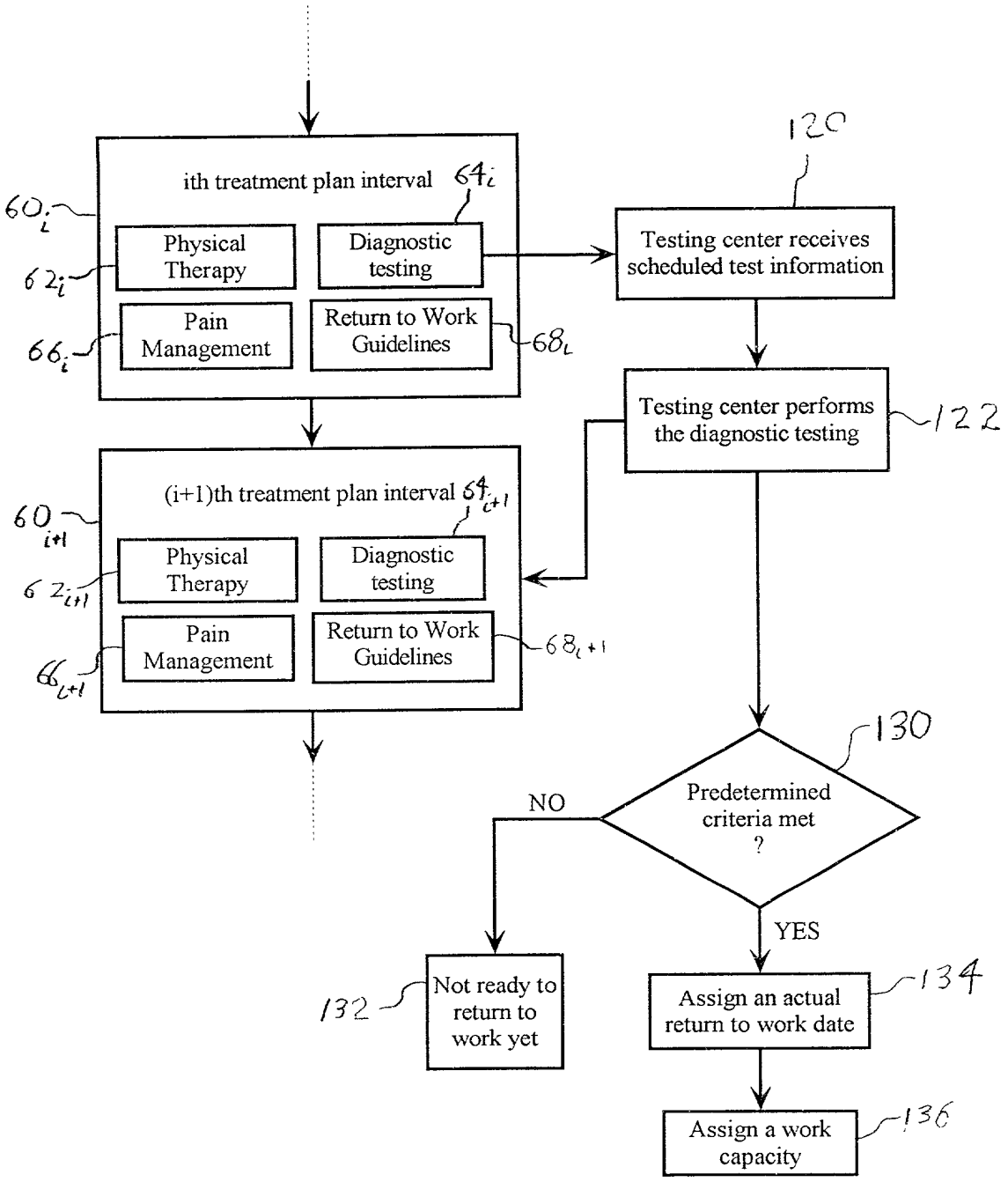
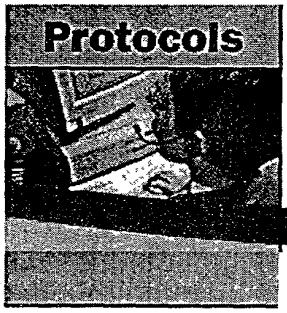

ith treatment plan interval
Physical Therapy
Diagnostic testing
Pain Management
Return to Work Guidelines
(i+1)th treatment plan interval
Physical Therapy
Diagnostic testing
Pain Management
Return to Work Guidelines
120
Testing center receives scheduled test information
Testing center performs the diagnostic testing
122
130
Predetermined criteria met ?
NO
YES
132
Not ready to return to work yet
Assign an actual return to work date
134
Assign a work capacity
136

FIG 6



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This is the suggested treatment plan for the selected diagnosis, treatment pathwa effective dates. If there are no services suggested for this treatment plan, you will ***None*** under suggested services. In addition, if you have not selected a treatment diagnosis, you will see ***None*** for suggested services and return-to-work guidelines

Claim Information A

Name:	Test Case2 UPDATE
Social Security #:	111 - 22 - 3333 UPDATE
Claim Number:	UPDATE
Tracking number:	59BEXW33
Last Day Worked:	3 / 29 / 2001 UPDATE
Date of Initial Treatment:	3 / 30 / 2001 UPDATE
Effected body part:	Shoulder
Diagnosis:	Rotator Cuff Tear
ICD9:	840.4
NCCI code:	None Find DoDM
DoDM:	
Total Claim Days:	
Physician of Record Code:	UPDATE
Treatment pathway:	Noninvasive
Treatment Intervals:	3/29/2001 to 4/11/2001

<Create New Claim> <Select An Activ

400 — **Services**
Diagnostic X-Rays
Physical therapy 3 Time(s) / week

schedule an X-Ray
402

600 — **Pain Management** Utilization of appropriate anti-inflammatory medication, pain medication, and muscle relaxants to facilitate optimum rehabilitation and recovery.

800 — **Return to Work**

Lower	
Bending/Stooping/Crouching	As Tolerated
Climbing Ladders	No
Driving	As Tolerated
Kneel/Squat	As Tolerated
Lifting Floor To Waist	5 Pounds
Operating Heavy Equipment	Not with Involved Extremity

Fig 7 (1 of 2)

800

Pulling/Pushing	5 - 10 Pounds
Sitting	As Tolerated
Standing	As Tolerated
Twisting/Planting	No Restrictions
Working on Scaffold	No
Upper	
Climbing Ladders	No
Continuous/Repetitive	As Tolerated
Gripping	As Tolerated
Lifting at Waist Height	5 Pounds
Operating Heavy Equipment	Not with Involved Extremity
Overhead Activity/Lifting	No
Pulling/Pushing	5 - 10 Pounds
Reaching	Waist Height Only

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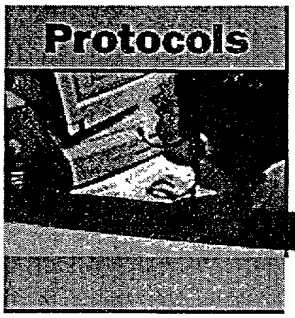
Fig 7 (2 of 2)



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The Reports include suggested Therapy Guidelines for each treatment diagnosis, treatment pathway, or interval(effective dates).

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Claim Information Arc

Name:	Test Case2 UPDATE
Social Security #:	111-22-3333 UPDATE
Claim Number:	UPDATE
Tracking number:	59BEXW33
Last Day Worked:	3/29/2001 UPDATE
Date of Initial Treatment:	3/30/2001 UPDATE
Effected body part:	Shoulder
Diagnosis:	Rotator Cuff Tear
ICD9:	840.4
NCCI code:	None Find DoDM
DoDM:	
Total Claim Days:	
Physician of Record Code:	UPDATE
Treatment pathway:	Noninvasive
Treatment Intervals:	3/29/2001 to 4/11/2001

<Create New Claim> <Select An Activit

200

Therapy Guidelines

- No immobilization
- Exercise
  - Begin full ROM, active-assisted ROM, pulley and T-Bar
  - isometrics - submaximal
    - external/internal rotation
    - infraspinatus/teres minor
    - deltoid
    - must be pain-free, full ROM
    - scapula stabilizers
      - rhomboids
      - levator scapulae
      - trapezius
      - serratus wall push-ups
      - posterior capsule, anterior capsule mobilization
- Modalities
  - Phono
  - Ultrasound
  - Cryo/ice

Fig 8 (1 of 2)

Ionto
EGS to posterior cuff
Aquatic Exercises
buoys for flotation - ROM
water walking - arms at side/palms foward
buoys with shoulders in 90 degree flexion/abduction
Manual Therapy
McConnell taping
frictional massage
Goals
decreased pain/swelling
increased ROM WNL
decreased painful arc
begin PRE
Patient Strength Education
lifting techniques
postural education

200

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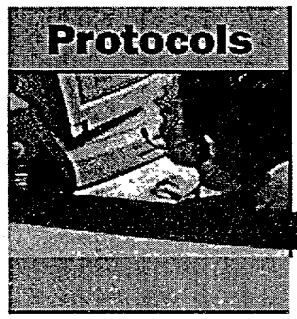
Fig 8 (2 of 2)



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<Select An Activ

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PHYSICIAN'S REPORT/TREATMENT PL
for Industrial Injury or Occupational Dise

INSTRUCTIONS

- Please print or type this report
- Be sure to enter four digits for the year in all date fields.
- Complete Part I and Part II of this form if this is the initial report/treatment plan, request for additional conditions or diagnosis has changed.
- If htis is a subsequent treatment plan, or if extending dates of disability, complete Part II only.
- Attach additional notes if needed.
- Mail or fax to employer's MCO or self-insuring employer.

900

Part I

1.	Injured worker name	Test Case2
	Social Security number	111-22-3333
	Claim number	
2.	Employer name	
3a.	Date of injury or diagnosis of disease	3/29/2001
3b.	Date of first exam	

4. Describe the industrial injury or occupational disease

5. Provide current diagnosis and ICD-9 code(s), location and site.

1.	Diagnosis	Rotator Cuff Tear
	Code	840.4
	Location	
	Site	

Fig 9 (1 of 5)

2. Diagnosis
   Code
   Location
   Site

3. Diagnosis
   Code
   Location
   Site

6. Complete if you are recomending additional condition(s) after the initial allowanc the claim. Supporting medical documentation is required for all conditions listed

900

1. Diagnosis
   Code
   Location
   Site

2. Diagnosis
   Code
   Location
   Site

3. Diagnosis
   Code
   Location
   Site

7. In your opinion is there a direct or porximate causal relationship between the diagnosis in 5 and/or 6 and the description of the industrial accident/exposure?

O Yes O No Please Explain

8. Are there any pre-existing conditions, impairments, complicating factors or disea processes that have been aggravated as a result of the injury or that could impa recovery?

O Yes O No...If yes, please describe

Fig 9 (2 of 5)

Part II

Injured worker name: Test Case2

Social Security number: 111-22-3333

Claim number:

9a. Date of last exam or treatment:

9b. Date of next appointment:

9c. Date of return to work:

O Actual O Released O Estimated

9d. Current period of disability due to the work-related injury/disease

From:

To:

900

10. Has the work-related injury(s) or occupational disease reached a treatment pla at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement)

O Yes O No

If yes, give date: If no, please explain

11a. What was the injured worker's position of employment at the time of the injury/disease?

11b. Is injured worker medically able to return to this position of employment?

O Yes O No If no, please explain

11c. Is injured worker able to return to other employment?

O light duty O alternative work O modified work O transitional work?

Please list any restrictions that may apply.

12. Is vocational rehabilitation needed to assist with return to original job or differe job?

O O

Fig 9 (3 of 5)

Yes No If yes, please explain in the treatment plan below.

13. Treatment plan:

☐ Treating diagnosis ICD Code(s)

840.4

☐ Initial date

☐ Subsequent date

Provide copies of current medical reports, and include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment, etc.

1. Specific Type of Treatment: X-Rays
   Meds:
   Frequency: 1 Time
   Duration: 2 weeks
   Location:
   Site:

2. Specific Type of Treatment: Physical Therapy
   Meds:
   Frequency: 3 Time(s) / week
   Duration: 2 weeks
   Location:
   Site:

14. The following clinical findings are the basis for my recommendations: (Attach additional sheet if necessary)

Objective: Subjective:

Physician basic & provider number mandato

CHECK ☐ if Physician of Record
I certify that the above information is correct to the best of my knowledge. I aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payments to which that person is not entitled, is subject to felony criminal prosesution any may under appropriate criminal provisions, be punished by a fine, imprisonment both.

Physicians Name:
Telephone Number:
Fax Number:
Physicians Address:

Fig 9 (495)

City:

State:

Zip:

BWC Provider Number:

Date: 3/30/2001

☐ Check the box if you want to attach Diagnostic Questionaire.

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Print Format

900

Fig 9 (5 of 5)

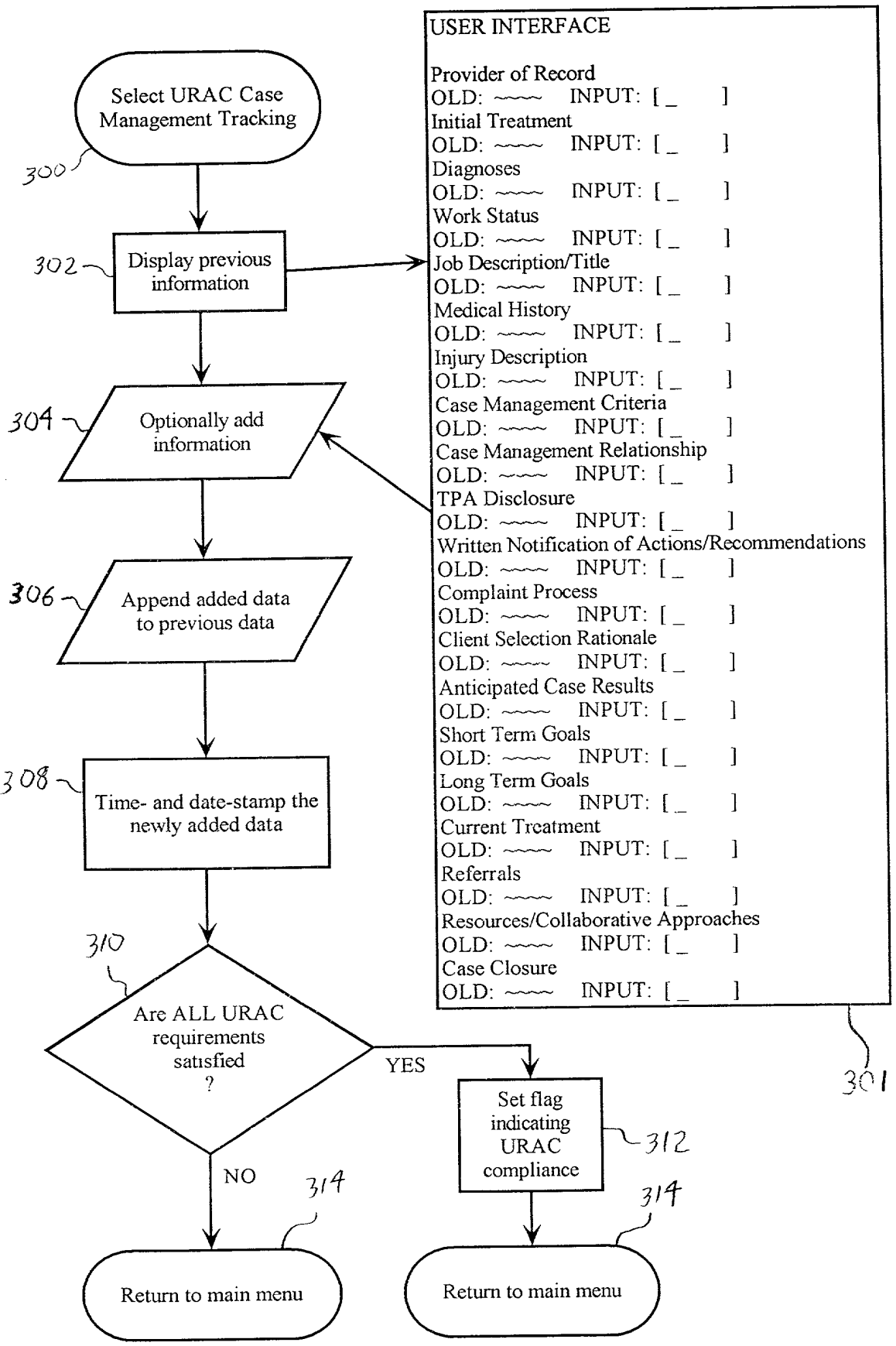
Select URAC Case Management Tracking
300
Display previous information
302
Optionally add information
304
Append added data to previous data
306
Time- and date-stamp the newly added data
308
Are ALL URAC requirements satisfied ?
310
YES
NO
Set flag indicating URAC compliance
312
Return to main menu
314
Return to main menu
314
USER INTERFACE
Provider of Record
OLD: ~~~ INPUT: [_]
Initial Treatment
OLD: ~~~ INPUT: [_]
Diagnoses
OLD: ~~~ INPUT: [_]
Work Status
OLD: ~~~ INPUT: [_]
Job Description/Title
OLD: ~~~ INPUT: [_]
Medical History
OLD: ~~~ INPUT: [_]
Injury Description
OLD: ~~~ INPUT: [_]
Case Management Criteria
OLD: ~~~ INPUT: [_]
Case Management Relationship
OLD: ~~~ INPUT: [_]
TPA Disclosure
OLD: ~~~ INPUT: [_]
Written Notification of Actions/Recommendations
OLD: ~~~ INPUT: [_]
Complaint Process
OLD: ~~~ INPUT: [_]
Client Selection Rationale
OLD: ~~~ INPUT: [_]
Anticipated Case Results
OLD: ~~~ INPUT: [_]
Short Term Goals
OLD: ~~~ INPUT: [_]
Long Term Goals
OLD: ~~~ INPUT: [_]
Current Treatment
OLD: ~~~ INPUT: [_]
Referrals
OLD: ~~~ INPUT: [_]
Resources/Collaborative Approaches
OLD: ~~~ INPUT: [_]
Case Closure
OLD: ~~~ INPUT: [_]
301

FIG 10